NC DIVISION MH/DD/SAS
2009 CAP-MR/DD SERVICES AUDIT

PROVIDER NAME:			**AUDIT DATE:**	
PROVIDER #:			**NAME:**	
CONTROL #:			**SERVICE TYPE:**	
MEDICAID #:			**PROCEDURE CODE:**	
DOB/AGE:			**SERVICE DATE:**	
RECORD #:			**UNITS PAID:**	
RATING CODES:	**O = No** **2 = partially met** **4 = Yes**	**6 = No service note** **7 = Unable to identify service provider**	**8 = Repaid 9 = NA**	**RATING**
AUTHORIZATIONS/CONTINUED NEED REVIEW/PLAN OF CARE (Use rating of "4" or "0" for Q 1-3				
1. a. Is an authorization in place covering this date of service? **b. If NO, list dates: FROM_____TO_____**				
2. a. Is the provider enrolled with Medicaid to deliver this specific service? **b. If NO, list dates: FROM _____TO_____**				
3. a. Is the date of service covered by a current Plan of Care? **b. If NO, list dates: FROM_____TO_____**				
SERVICE DOCUMENTATION (Use Likert Scale See Guidelines): **(Use rating of "4", "2" or "0" for Q 4-9 and "4" or "0" for Q10—or 6, 8, or 9 as applicable)**				
4. Is the documentation initialed and signed within the designated time frame by the person who delivered the service?				
5. Does the service note(s) relate to goals listed in the CNR/POC?				
6. Does the documentation reflect treatment for the duration of service?				
7. Does the service note reflect assessment of progress toward goals?				
8. Does the documentation indicate that the requirements of the CAP-MR/DD Waiver were met for this service?				
9. Do the units documented match units paid? **If no write number of units documented: _____**				
QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 11-14—or 6, 8 or 9 as applicable)				
10. Is there documentation that the staff is qualified to provide the service billed?				
11. a. Is an individualized supervision plan in place for paraprofessional and AP staff? **b. Has the plan been implemented?** **c. If "b" is NO, list dates: FROM:_____ TO:_____**			**a.** **b.**	
12. a. Did the provider agency conduct a criminal background check on the staff person(s) who provided this service? **b. If NO, list dates: FROM:_____ TO:_____**				
13. a. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? **b. If NO, list dates: FROM:_____ TO:_____**				
COMMENTS:				
AUDITOR:			**LME:**	